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Can training improve the confidence and skills of inpatient staff working with Complex Trauma?

Abstract

Objective: Studies show that experiences of repeated or complex trauma are very common in patients with severe mental health problems. Unfortunately, many professionals do not routinely ask about abuse, due to concerns about how to ask and respond. This project sought to identify the needs of inpatient staff and developed a tailor-made training package. **Method:** A training program was developed from focus-group discussion and delivered to the team. Questionnaires were administered pre-, post-training and at three-month follow-up, to assess changes in knowledge, confidence and worries in the assessment and treatment of complex trauma. **Results:** There was an increase in self-reported staff confidence ($p = .001$) and knowledge ($p = .028$) about working with complex trauma and their worries decreased ($p = .026$) between pre- and post-training. **Conclusions:** In order to sustain the benefits of training for longer, recommendations were made to the service for on-going training, supervision and evaluation.

Key words: complex trauma, complex PTSD, staff training, service improvement, program evaluation

Complex trauma or complex posttraumatic stress disorder (CPTSD) was proposed by Herman (1992) to describe a syndrome of prolonged and repeated trauma. It came into being when some forms of trauma were found to be much more pervasive and complex (Herman, 1992). Childhood abuse that occurs over an extended time period is one such example (Courtois, 2004). Complex trauma suggests clusters of symptoms relating to affect regulation, consciousness, self-perception, perception of the perpetrator, relations with others and systems of meaning (Cloitre et al., 2011; Herman, 1992; Resick et al, 2012).

While there is growing attention to the concept of complex trauma, mixed views precluded the development of a diagnosis in DSM-V (American Psychiatric Association, 2013). On one hand, experts in the field argue for the inclusion of a distinct subtype of PTSD that more adequately captures the above cluster of symptoms, with such recognition seen as being the precursor needed for the development of research (Herman, 2012). On the other hand, the dearth of new research into the validity of complex trauma since DSM-IV has led to conclusions that there was insufficient evidence for complex trauma to be included as a subtype in DSM-V (Resick et al., 2012). In comparison, the International Classification of Diseases 11th version (ICD-11; World Health Organisation, 2015) is likely to include complex trauma as a separate diagnosis, due to an emphasis on different diagnostic criteria and as a less conservative approach has been taken than DSM-V's requirement for a large burden of scientific proof (Friedman, 2014).

The association between complex trauma and other diagnoses

Studies have previously reported an association between complex trauma and Borderline Personality Disorder (BPD) (Ford, 1999; McLean & Gallop, 2003; Yen et al., 2002; Zanarini, Yonge, & Frankenburg, 2002), although a more recent study by van Dijke et al. (2012) found only a 26% overlap between CPTSD and BPD. The overlap between complex trauma and BPD is in terms of; symptoms, such as impaired interpersonal functioning, impaired sense of self,

dissociative experiences, anger, impulsivity, and self-harm; and theorised causal links to trauma exposure (Resick et al., 2012). Similarly, there is considerable research demonstrating that child abuse and neglect are significant causal factors in psychosis (Read, Fink, Rudegeair, Felitti & Whitfield, 2008). A review of studies by Read et al. (2008) highlights a dose-response effect, whereby the greater the frequency and/or severity of childhood abuse, the more likely an individual is to develop psychosis. Read et al. (2008) discuss the implications of this in terms of clinical practice and recommend that all mental health professionals take trauma histories with all patients. It is worth noting that traumatic experiences may not be present in the history of all people with diagnoses of BPD or psychosis.

The phase-based treatment approach

While NICE (2005) guidelines exist for the management of Type I (*single* event) PTSD in the United Kingdom, research shows these guidelines to be inadequate in addressing the range of dimensions that Type 2 or *complex* trauma involves. It has instead been suggested that a phase-based approach be used (Courtois & Ford, 2013; Herman, 1992), with an initial period of stabilisation advocated and termed the phase one of treatment. Aspects of it can be delivered by any clinical staff member, such as enabling a client to attend to their safety and to develop grounding skills to cope with flashbacks and dissociative experiences (Courtois, 2004). Following stabilisation, treatment can progress to the second phase of remembering the past; and then the third phase of recovery within the context of therapy with a trained psychologist.

While training programs such as the Auckland Training Program have been developed based around the three-phase approach (Cavanagh, Read & New, 2004), there are currently limited published evaluations of their treatment effects. Increasingly, the need to develop guidelines on trauma competencies for the education and training of psychologists has been noted in the literature, with recent publications from the International Society for Traumatic Stress Studies

(ISTSS; Cloitre et al., 2012) and the American Psychological Association (APA; 2015). Similarly, the Board of the UK Psychological Trauma Society (UKPTS) have recently reviewed the available published evidence to inform clinical and service planning guidelines, with the British Psychological Society circulating this guidance in draft format for consideration by its members (2016). What is yet to be addressed is how complex trauma training can be disseminated to other core health care professionals.

The need to ask about abusive experiences

The UK Department of Health published a briefing paper on Implementing National Policy on Violence and Abuse (NHS Confederation, 2008) that acknowledges the links between violence, abuse and mental health diagnoses. It makes recommendations for staff in the National Health Service (NHS) to be trained in routinely and consistently asking all patients about abuse at first contact and subsequent assessments. Despite this, many professionals fail to ask about abuse (Read, Hammersley & Rudegeair, 2007; Read et al., 2008). Barriers to asking can include concerns about distressing clients; fear of vicarious traumatisation; fear of inducing “false memories”; more immediate service concerns; the client having a diagnosis of psychosis and the clinician having a strong belief in biogenetic causal factors; and lack of training in how to ask and respond (Read et al., 2007; 2008). Given the high prevalence rates of abuse histories amongst mental health service users, failure to ask may leave a significant proportion of patients at risk, as CSA is suggested to be a better indicator of suicidality than depression (Hepworth & McGowan, 2012).

Inpatient staff training

The improvement of adult inpatient care in the NHS through delivering and evaluating training was initially highlighted as a policy priority (Department of Health (DoH), 1999; 2002) and continues to be on the agenda, with particular attention paid to registered nursing staff and

healthcare assistants (NICE, 2014). Methodological and practical concerns of organising staff training within inpatient settings exist (Bee et al., 2005; Milne & Roberts, 2002). Organisational challenges such as staff shortages and a lack of commitment by management can be frequent barriers to training implementation and need to be considered (Bee et al., 2005).

Aims and hypotheses

The aim of the current project was to; firstly, identify the requirements of inpatient staff in working with complex trauma, by meeting with the ward manager to perform a context analysis of the service and by holding focus groups with staff to ascertain their collective training needs. Secondly, the project sought to provide bespoke training to meet these identified needs and evaluated the outcome.

It was hypothesised that training would:

- significantly improve the knowledge and confidence of staff to ask about trauma histories and to be able to provide some brief stabilisation interventions (phase one) to distressed individuals on an inpatient ward
- significantly reduce worries or concerns about working with complex trauma.

Method

Design

The project was approved by (edited out for blind review). The project utilised a cross-sectional and mixed methods design, with a three-month follow-up. Qualitative data was generated from conducting focus groups with staff prior to developing the training; while quantitative data was collected at pre-training, post-training and follow up time points.

Participants

All clinical staff from an NHS inpatient ward were invited to participate. Information sheets were provided and written consent completed. Seven members of staff attended the two initial focus groups to discuss the training. Pre-training questionnaires were completed by 23 members of staff, either at the end of the focus groups or prior to training. In total, 15 staff members attended the training, including ward and clinical team managers; nurses; student nurses; and health care assistants. Of the 15 who attended training, two did not complete pre-training questionnaires. Therefore, there were 13 staff members who completed both pre- and post-training questionnaires and seven of these staff completed a further questionnaire at three-month follow-up.

Measures

Qualitative focus group questions.

A structured interview schedule was utilised to elicit participants' responses to set questions. The questions asked about the participants' current understanding and knowledge about complex trauma; and their worries about asking about trauma.

Quantitative questionnaire.

No standardised measure currently exists to assess staff training in working with complex trauma. A self-report questionnaire has previously been designed and piloted in the present Trust (Walters et al., 2016). This was adapted with permission to produce a 17-item questionnaire. Four items were designed to assess confidence; five to assess current knowledge; and seven to assess worries. Each item is rated on a five-point Likert scale, ranging from "Strongly Agree" (5 points) to "Strongly disagree" (1 point). Total subscale scores could therefore range from 4 to 20 for confidence; 5 to 25 for knowledge; and 7 to 35 for worries. A higher score indicates a greater amount of confidence, knowledge or worries.

Procedure

The procedure was guided by the NHS Institute recommended model for service improvement (PDSA; Langley, Nolan, Nolan, Norman, & Provost, 2009). This model includes a cyclical process of 'Planning' for change, 'Doing' or implementing changes, 'Studying' the effects of such changes and 'Acting' on the outcomes of evaluation.

- **Plan** The ward managers and clinical staff were key stakeholders in this process. The planning highlighted ways to minimise obstacles and optimise opportunities. Shift patterns were taken into account by organising two focus groups on different days and the ward manager organised the rota three months prior to the training day, to ensure as many permanent members of staff as possible were available to attend one of the two training slots. In addition, posters were utilised to advertise the focus groups and increase staff awareness of the training.
- **Do** Two focus groups were held in the month before training, whereby a convenience sample of staff members were invited to discuss and identify their collective training needs for working with complex trauma. The focus group discussion primarily guided the format of the subsequent training and, to a lesser extent, the content. The discussions were audio-recorded, transcribed and analysed thematically. The subsequent training materials were developed from an existing training program (C. Gilmore, personal communication, January 2015) for delivery to similar teams within the Trust. Themes identified from the literature and the focus group were used to tailor the training to meet the needs of the team. Two training sessions were offered to staff that incorporated PowerPoint, group discussion and experiential skills learning.
- **Study** A questionnaire was administered prior to the training session, to measure the confidence, knowledge and worries of staff in assessing complex trauma and

managing the distress on the ward. Post-training questionnaires were administered immediately after the training, to assess changes in these three constructs. The team were given three months to implement the material and skills from training. A follow-up questionnaire was then administered to assess longer term change in working with complex trauma.

- **Act** this project acted as an initial stage of change for service improvement on an inpatient ward and this will be described in the recommendations later.

Analysis

Qualitative data analyses.

The qualitative analysis of the focus groups was conducted according to Braun and Clarke's (2006) suggested methodology for six phases of thematic analysis in psychology. The researcher took a realist epistemological stance to the analysis, as it was felt that the focus groups would represent a true account of the reality of the participants. An inter-rater reliability check was completed to demonstrate trustworthiness and confirmability, as qualitative research is often criticised for lacking scientific rigor (Noble & Smith, 2015). A 50% sample of transcribed text was separately analysed by a researcher unrelated to the project. The progressive maps were discussed and the two final thematic maps were compared. Where a difference was identified, the rationale for this was debated until mutual agreement between the two analysts including minor refinement of theme and sub-theme levels. A final thematic map was therefore produced.

Quantitative data analyses.

Data was entered into an SPSS statistics software version 20 (IBM). The data was inspected visually and checked for outliers. It met the required assumptions for normality and sphericity, therefore, parametric tests could be conducted on the data. Three repeated measures ANOVA's

were performed to analyse confidence, knowledge and worries. Planned pairwise comparisons were conducted for pre- and post-training data (T1-T2); pre-training and follow-up data (T1-T3); and post-training and follow-up data (T2-T3).

Results

Qualitative Focus Group

In response to aim one, thematic analysis yielded several key themes which shaped the training program. Four main themes evolved, with a number of subthemes clustered around each main theme:

1. *Understanding the heterogeneity of client experiences*
2. *Negative past experiences*
3. *Challenges to working with trauma*
4. *Training needs and preferences*

Understanding the heterogeneity of client experiences.

Staff members demonstrated different levels of understanding of complex trauma experiences for patients. The heterogeneity of client trauma experiences was discussed, in terms of there being a number of different causes to trauma. There was some reported confusion around single event trauma (type I) and complex (type II) trauma experiences.

“Car accidents—that causes PTSD, doesn’t it?”

“Death in the family...”

“And physical abuse or sexual abuse”

Staff described how they thought people can respond differently to the same potentially traumatising circumstances.

“Well, I was thinking that trauma is different for different people, isn’t it? Because what might be just nothing to me might be quite devastating for somebody else. So it’s defining trauma really that I found quite difficult when I was filling the form out. Because there’s-- different people classify it differently, don’t they?”

There was some uncertainty in understanding whether an individual could have both a diagnosis of BPD and trauma.

“It says in her notes that she has been abused. Can someone have two diagnoses?”

The training therefore covered information about what complex trauma is, how it is different to PTSD, and the association between complex trauma and diagnoses such as BPD and psychosis, to aid understanding of client’s and staff’s experiences on the ward.

Negative past experiences.

The difficult client experiences that tend to be associated with complex trauma also have considerable impact on the resources of a staff team. Ideas about team splitting and boundaries emerged, and the resulting effects on staff morale. In particular, past experiences of feeling powerless and disconnected when working with Personality Disorders as a staff team resonated with a number of staff members.

“In the past we’ve had, you know, with personality disorders... that there is a lot of team splitting. And that’s difficult.”

“I didn’t get involved in it. But there were certain members of staff on the ward who were... over-involved, I feel. So I kept my distance from it really. It affected staff morale for a time.”

“It happens more than once, and these chosen ones, they just laid their own boundaries”

“If you told people or asked people to back off they said “no, we’re not”. And there’s that splitting of the ranks.”

From these themes, it was identified that previous negative experiences may be influencing staff morale and therefore the care they are able to provide to client’s who demonstrate more challenging behaviours. It seemed important to include in the training that BPD can be more compassionately understood as a complex trauma reaction (although not everybody with a diagnosis will have experienced trauma). The importance of staff self-care was also included in the training, although this was not the focus of the training package.

Challenges to working with trauma.

A number of perceived barriers seem to get in the way of the staff team being able to work as confidently and competently as they would like with clients with complex trauma experiences. Asking about traumatic experiences seemed a particular worry, with emphasis placed on the words used and the impact of these words on the patients.

“I don’t know what to say to some people when they are distressed”

“I worry I will make it worse, use the wrong words”

These worries in turn lead to an avoidance of talking about trauma, with a sense of responsibility for any distress caused being shouldered by the staff.

“I try not to talk about it unless they want to”

“They might hang onto my words”

“Because sometimes you shouldn’t ask. It will make things worse and—like, the patient escalates.”

A lack of confidence in their own abilities and awareness about the role of the ward in stabilising distressed individuals was also apparent from the discussions.

“Can we do that?”

“We haven’t really had any training in that... us health care assistants”

As well as the training covering the role of inpatient staff in providing stabilisation to clients as part of the three-phase approach, time was also dedicated to discussing how to ask about trauma. This included examples of the language that could be used by staff.

Training needs and preferences.

The staff preferences for the content and method of delivery of training were mixed, and at times, conflicting in their ideas. This confusion about their collective training needs may have reflected the confusion staff felt about understanding and working with complex trauma.

“I also want to know, like, can they get better?”

“Have a broad overview, but then more detail”

“Like, some things to read, but also that we want to talk about it”

More directive questioning elicited preferences for informal and discussion-based training that was supplemented by written material and skills-based training.

“Some skills I can take away”

“I quite like talking around a table. But maybe have some, headings or, you know-- I think PowerPoint-- it just gets lost.”

From this discussion, the format of the training was devised. The training was set-up around a table to aid discussions, in view of a projector screen. PowerPoint was used with frequent discussions to explore the ideas and to draw on the current experiences and resources of staff.

The training provided skills through experiential exercises. Hand-outs and worksheets summarising the phase-one skills were given out to staff to aid practise. Table 1 summarises the content of the training workshop that was delivered.

Insert Table 1 here.

Quantitative results

To evaluate the outcome of the training for aim two, questionnaire completions rates and demographics are presented in Table 2 and data analysis for all measures at pre-, post- and three-month follow-up evaluation is presented in Table 3.

Insert Tables 2 and 3 approx. here

A repeated measures ANOVA determined that mean confidence differed statistically between time points ($F_{(2,12)} = 18.0, p < .001$). *Apriori* comparisons using the Bonferroni correction revealed that staff training elicited an increase in confidence from pre-training to post-training (10.6 to 16.0) that was significant ($p = .001$). However, this was not maintained between post-training and follow-up (16.0 to 13.7; $p = .128$).

A significant difference in knowledge was found across time ($F_{(2,12)} = 8.0, p < .05$). *Apriori* comparisons using the Bonferroni correction revealed that staff training elicited an increase in knowledge from pre-training to post-training (14.4 to 16.7) that was significantly different ($p = .028$). Overall, staff knowledge increased from pre-training to follow-up (14.4 to 18.1), which was statistically significant ($p = .042$). However, the increase observed between post-training and follow-up (16.7 to 18.10) was not significant ($p = .66$). Therefore, the significant change in knowledge occurred between pre-and post-training.

A significant difference was also found for worry across time $F_{(2,12)} = 11.4, p < .05$. *Apriori* comparisons using the Bonferroni correction revealed that staff training elicited a decrease in worry from pre-training to post-training (26.3 to 19.7) that was significant ($p = .026$). However, this change was not maintained between post-training and follow-up (19.7 to 21.0; $p = .964$).

Discussion

This project used a mixed-methods design to firstly ascertain the training needs of clinical staff from an inpatient ward in working with complex trauma, through discussion with the ward manager and staff. Secondly, the project aimed to impact on the confidence and skills of inpatient staff working with individuals with complex trauma, by providing training to the clinical staff team and to evaluate the outcomes of this training. This discussion is embedded within the NHS Institute model for service improvement – “Plan, Do, Study, Act” (PDSA; Langley et al., 2009).

Impact of focus groups

In line with the first aim, the training needs of staff were elicited by dedicating time to planning with the key stakeholders and this constituted the “Plan” stage of the NHS Institute model (Langley et al., 2009). This planning enabled service needs and barriers to be identified and circumvented, such as being mindful of safe staffing levels and taking account of rota patterns for optimal attendance. Equally, staff needs and barriers could be identified through holding the focus groups, and training developed accordingly. The resulting tailor-made training program appeared to address these needs and barriers, by promoting discussion and providing materials to facilitate understanding and skills. As such, it represented the “Doing” stage of service improvement (Langley et al., 2009).

The literature highlights the importance of inpatient staff asking about and responding to abuse disclosures; whilst also acknowledging the barriers to asking, such as concerns about

distressing clients and a lack of training in how to ask and respond (Read et al., 2007; 2008). Consistent with the literature, several barriers to assessing for and treating trauma were identified by the team. In particular, within the theme of “*the challenges of working with trauma*”, worries about distressing clients by using the wrong words was elucidated. The theme “*understanding the heterogeneity of client experiences*” illustrates the confusion of staff in knowing the differences between PTSD and complex trauma; and whether someone can have more than one diagnosis. This seems to mirror the controversy within the literature about the construct of complex trauma and the implications for diagnostic criteria in DSM-V (Herman, 2012; Resick et al., 2012) and ICD-11 (Friedman, 2014) and suggests the need for training.

Impact of training

In response to the second aim, the questionnaire data indicates that staff confidence and knowledge about working with complex trauma increased following the training session and worries about working with complex trauma decreased. This formed the “Evaluate” stage of the model (Langley et al., 2009) and replicated the findings of the Auckland training program (Cavanagh et al, 2004) to provide additional support for the utility of training.

Whilst an overall increase in confidence and knowledge and a decrease in worry was found at three-month follow-up, the substantive and statistically significant change occurred between pre-and post-training. Staff were encouraged to consider how they could use the ideas from the training in their daily roles, but this seems unlikely to have been sufficient to sustain changes to follow-up. That being said, the observed trends for an increase in knowledge and confidence; and a decrease in worry were in the right direction between post-training and follow-up time-points; and didn’t recede to pre-training levels. Overall, this is consistent with the challenges of sustaining change following training to follow-up time periods that has previously been

noted (Bradshaw, Butterworth, & Mairs, 2007; Milne, Westerman & Hanner, 2002; de Silva, 2014).

Trauma-informed service implications

This project forms the initial “Act” stage of service improvement, with continued cycles implicated (Langley et al., 2009). A number of learning points can be drawn from this process and the recommendations made to the specific service, for the consideration and application to other developing trauma-informed services. Whole team training is recommended to promote a consistent approach towards trauma. Within this, separate sessions based on experience levels may be warranted (Bradshaw et al., 2007). Recruiting both managerial and clinical “change champions” to generate “buy-in” to new practises through top-down and bottom-up methods is considered most effective (de Silva, 2014). It has been suggested that this is particularly useful when seeking to appeal to doctors (de Silva, 2014). Psychiatrists have been found to be particularly unlikely to receive training in abuse issues despite being key members of the multi-disciplinary team and frequently responsible for initial assessments (Cavanagh et al, 2004).

Greater consideration of the barriers to training implementation may be addressed using a relapse-prevention design (Milne et al., 2002), to identify likely struggles and use group problem-solving to negotiate this. The training could further be supported by offering a regular supervision slot or trauma-focused case discussion, as it has been suggested that this can help to maintain the changes achieved through training to follow-up (Bradshaw et al., 2007).

Study limitations and research implications

Collecting more information on the reasons why participants could not be followed-up would be useful. By negotiating such barriers, the number of participant responses at follow-up may increase and in turn would increase the number of participants who could be included in the statistical analyses at all three time points. The training materials were drawn from evidence-

based practice and were developed for the service. While this may have been more effective than a standardised training package, the lack of validation may limit external validity. The questionnaires were developed to assess the key components of training as highlighted from the literature and previously piloted in the Trust. However, they have not been assessed for criterion validity and therefore some caution must be taken when drawing conclusions about the efficacy of improvement when employing a non-validated measure. In addition, the follow-up period may have not given participants sufficient time to deploy their new knowledge and skills, for sustained statistical and reliable change to be observed three months later. However, a longer follow-up time period may have increased the likelihood of attrition due to staff turnover and sickness. This could render the response rate too low for meaningful analysis. Future research studies may want to consider how to balance this trade-off, to ensure adequate time for training implementation against the possibility of participant attrition. In addition, future studies may like to additionally consider using a more direct measure of clinical impact such as changes to staff behaviour, to ascertain whether changes in confidence, knowledge and worries translate into improvements of clinical care. As this area of work is developmental, the findings of the current study are useful in directing future larger scale studies.

Conclusion

This project sought to identify the needs of inpatient staff and developed a tailor-made training package to address these needs and barriers. Self-reported staff confidence and knowledge about working with complex trauma increased following the training, and worries about working with complex trauma decreased. In order to sustain the benefits of training for longer, a number of recommendations were made to the service. Making the provision for on-going training and supervision will form a crucial part of future service development as a trauma-informed service. The continued evaluation of tailor-made training is indicated as part of this development.

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Table 1

Overview of Training Workshop

Overview of training, introduction and case study.
Discussion about traumatic experiences, clarifying what people currently understand. Psychoeducation about the spectrum of trauma diagnosis and also key features of complex trauma identified from the current literature.
Information about the prevalence of childhood abuse and National statistics. Also local data from a survey of services within the Trust with regards to the current picture of working with patients with traumatic expertness.
Group discussion about how traumatic experiences present. Information about the similarities, differences and overlap between psychosis, complex trauma and Borderline / Emotionally Unstable Personality Disorder.
Psychoeducation about the phased-based approach to recovery from trauma and discussion about how all clinical staff members are able to help provide the safety and stabilisation phase of the pathway. Re-visiting case study to demonstrate the principles..
Discussion about asking about abuse, the principles of asking, using a “funnel” approach to questions, and possible issues to cover in a psycho-social history assessment. Small group discussion about how clinicians tend to ask the questions and sharing of good practice.
Introduction to skills and techniques that can help achieve a sense of safety and stabilisation for patients on the ward. Experiential practice of grounding skills, soothing smells, safe place imagery and safe object.
Discussion about self-care. Implications for clinical practice and taking ideas forward as a trauma-informed service.

Table 2

Demographics and Questionnaire Completion Rates

	Pre-training	Post-training	3-month follow-up
Demographics	N=21	N=13	N=7
Gender			
Male	5	4	2
Female	16	9	5
Designation			
Senior Manager	1	1	1
Manager	1	1	1
Registered Nurse	5	4	2
Student Nurse	2	1	0
Healthcare Assistant	12	6	3

Table 3

Descriptive Statistics and ANOVAs for Study Variables

	Pre-training		Post-training		Follow-up		ANOVA	Pre-post	Pre-follow	Post-follow
	N=21		N=13		N=7		N=7	N=13	N=7	N=7
Variable	M	SD	M	SD	M	SD	F	M diff	M diff	M diff
Confidence	11.43	2.40	15.46	2.57	13.71	2.93	18.0 **	-5.43 **	-3.14 ns	2.27 ns
Knowledge	16.76	3.33	17.38	1.76	18.14	1.68	14.2 *	-2.29 *	-3.71 *	-1.43 ns
Worries	24.62	4.12	21.62	7.08	21.00	6.45	11.4 *	6.57 *	5.27 *	-1.27 ns

Note. N = number; mean = M; standard deviation = SD; M diff = mean difference for pairwise comparisons

* = $p < .05$, ** = $p < .001$